The extent of the cavity is greater than any heretofore described, and in fact has even been regarded as impossible. The patient's first symptom was a weakness in the left foot developing when he was seventeen years old, which progressed slowly until, in six years, the whole left side was paralyzed. The right side then became gradually weaker, and four years later he was completely helpless. Examination showed atrophy of the right side of the tongue with a marked impairment of the sense of taste, especially on that side. There was great impairment of motion in the arms, especially in the right. There was considerable wasting of the arms more marked in the distal portions. The right leg also was more affected than the left, and was 2½ inches shorter. Sensation for touch was felt normally throughout the body, but for pain and thermal sensation the disturbance was pronounced. The patellar jerk was exaggerated on the right side and diminished on the left. Death was due to bronchopneumonia. The cavity in the spinal cord began in the lower sacral region in the left posterior horn to which it was still confined in the upper sacral and lumbar region. From the midthoracic region upward the spinal cord was distorted and flattened. In the medulla there were distinct cavities in each anterior pyramid; the one on the right side being larger and cutting off the fibers of the hypoglossal nerve on that side. In the upper part of the medulla the cavity in the left anterior pyramid had disappeared. In the pons; the cavity in the right side extended nearly to the raphe. The right adducens fibers were degenerated. In the right cerebral peduncle the cavity was a narrow slit in the substantia nigra and extended into the upper part of the crusta near the median side of the peduncle. In the lower part of the internal capsule the cavity divided; one part soon terminated, but the other extended upward to within two or three millimetres of the lower surface of the lateral ventricle, but did not open into the ventricle. Schlesinger, in his monograph, says that in syringobulbia the cavity does not extend above the fifth nerve and involvement of the first four cranial nerves indicates a complicating lesion. This case shows that the third, fourth, or fifth cranial nerves might be involved by a cavity and that symptoms in the distribution of these nerves need not necessarily imply a complicating lesion. The atrophy of the right side of the tongue is explained by the complete degeneration of the hypoglossal nerve and its nucleus. C. D. CAMP (Philadelphia).

DISLOCATION OF VERTEBRÆ IN LOWER CERVICAL REGION. William C. Krauss Annal. of Surg., November, 1906).

In connection with a review of the literature on this subject, Dr. Krauss reports an interesting case of dislocation of vertebræ in the lower cervical region, followed by symptoms of complete severance of the spinal cord. Laminectomy was performed with a result of partial restoration of function later. The report is in brief: Male, 22, healthy, dived into shallow water, became semi-conscious and devoid of power in arms and legs. On admission to hospital there existed total paralysis of legs; arms and hands partially paralyzed. Speech, eyes, pupils and facial muscles not affected. Head slightly retracted, but moves in all directions with some pain. Tenderness over spinous process of the fifth cervical vertebra, and indefinite pain about third thoracic spine. Pulse slow, full, and good tension. Heart normal, respiration diaphragmatic, no temperature. Patellar, ankle and plantar reflexes absent. Marked priapism. Patient able to flex arms, but not to extend them. Movements of fingers and thumb impossible. Extension and flexion of forearm greatly weakened. Adduction of arm, pronation and supination of forearm very weak. Considerable weakness of deltoids, triceps, and chest muscles, also muscles about scapula and paralysis of serratus magnus. Triceps and biceps tendon reflexes absent. Zone of anesthesia corresponds to the level of the second intercostal space, is symmetrically limited to ulnar side of the arm and forearm, including the middle, ring and little fingers, and is for both temperature and tactile senses. Abdomen tense, reflex lost; likewise the cremasteric. Incontinence of feces. Condition diagnosed as complete severance of cord at level of sixth cervical. Placed on water-bed and traction to head. In few days bed sores developed and mild cystitis appeared. Eighteen days later laminectomy of fifth and sixth cervical performed by Dr. Roswell Park. Sixth cervical apparently abnormally loose. Dura appeared normal, but contained large amount of cerebrospinal fluid. Remains of old clot found. Cord seemed flattened and shrunken. No constriction above or below. Wound closed with buried and superficial drainage. On leaving hospital four weeks later the condition was: Can move head freely without pain. Area of anesthesia not materially changed. Can raise arm over head and flex forearms, but flexors of hand are weak; likewise pronation and supination. Can draw right leg as far as left knee; extension and flexion of right foot quite strong. Left leg can be drawn up to middle of right leg; extension and flexion of foot very weak. Patellar and plantar and Babinski's reflexes exaggerated; ankle and patellar clonus present. Abdominal and cremasteric reflexes still absent. Priapism disappeared and can tell when bladder and bowels are going to act, though can't control sphincters. Involuntary contraction of leg muscles and spasmodic flexion of legs and feet an annoying symptom. Eight months later, patient inclines slightly forward; Romberg present; flexes right leg upon thigh and pelvis, but can lift left leg only three inches from floor. Can walk with support. Tendency to fall backward. Gait is spastic; drags toe of left foot. All motion of arms and shoulders free. Pronation and supination of forearms good; likewise extension of wrist. Closes right hand fairly well, writes easily and uses telegraph key. Can open and close left hand, but without much power. Tendon reflexes of triceps, biceps and forearm muscles exaggerated, muscle reflexes heightened. Abdominal and cremasteric reflexes absent. There is still some difference of sensation at level of original zone. Temperature and tactile sense of left leg normal, but in right leg cannot distinguish between hot and cold. Breathing still diaphragmatic. This case is of interest since it shows a marked regeneration and recovery of function following a late operation.

H. C. Cowles (New York).

The Blood Pressure in Paresis. G. L. Walton (Journal A. M. A., Oct. 27).

In order to test the correctness of the general belief that the blood pressure in paresis is low, the author has examined 108 male patients with this disease in the Massachusetts hospitals for the insane, with special reference to this point. He used the Riva-Rocci instrument and employed the ordinary precautions in making the observations. The average of all the observations indicated a high rather than a low pressure, but to eliminate the influence of renal and arterial conditions, he separately tabulates the results in forty-four cases, without record of renal, cardiac or arterial disease, which show a tendency to hypotension rather than to hypertension.